WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

09600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County 247 Offutt Street
City or town Cumberland, Allegany Co.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 247 Offutt St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 47 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 247 Offutt Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MARY ADAMS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Merrill Adams
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1891

8. AGE: Years	Months	Days	If less than one day
47	9	8	hrs. min.

9. Birthplace Cumberland, Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At home

FATHER
12. Name Simon E. Helgoth
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Mary Fisher
15. Birthplace Cumberland, Md.

16. Informant ~~Chas~~ Merrill Adams
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7, 1939 (month) (day) (year)
Cemetery or crematory Greenmont Cemetery
Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. Oct. 7 1939 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar
Dr. R. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/39 19 , at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/30/39 19 to 10/3/39 19 , and that I last saw h alive on 10/4/39 19

Immediate cause of death	DURATION
Malignant hypertension	
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard J. Williams, M.D.
M. D. or other
Address 34 Va. Ave., Cumberland, Md. Date signed 10/6/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-8)

09601

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Harpersville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 15 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Harpersville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Lonaconing, Md

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Ellen M. Anderson

3. (b) Social Security Number —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John R. Anderson

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1887

8. AGE: Years 52 | Months 3 | Days 3 | If less than one day: ____ hrs. ____ min.

9. Birthplace Lonaconing, Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Moze Johnson

13. Birthplace Lonaconing, Md

MOTHER 14. Maiden name Barbara Ritter

15. Birthplace Lonaconing, Md

16. Informant John R. Anderson

Address Harpersville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1939 (month) (day) (year)

Cemetery or crematory Old Coney Cemetery

Location Lonaconing, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. Oct. 14 1939 (Date rec'd by registrar) Dr. E. Dan Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11th 1939, at 8 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1st 1939, to Oct 11- 1939, and that I last saw h— alive on Oct 10 1939

Immediate cause of death	DURATION
Carcinoma of liver	3 mo.
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. E. Dan Tyler M. D. or other

Address Lonaconing Date signed Oct 14-1939

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

09602

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 8 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Hardy

City or town: Moorefield Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Benjamin Baker

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): September 25, 1939

8. AGE: Years: 14 days; Months; Days; If less than one day ____ hrs. ____ min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Harmon Baker
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mary Funkhouser
15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1939 (month) (day) (year)

Cemetery or crematory: Baker Cem

Location: Baker, W. Va.

18. Funeral director: Harmon Baker Father

Address: Baker W. Va.

19. Oct. 9, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1939, at 1:11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1st 1939 to Oct 9th 1939, and that I last saw him alive on Oct 9th 1939.

Immediate cause of death

Due to: Congenital atresia of oesophagus — DURATION: 14 days

Due to

Other conditions: Inanition — 5 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Post mortem
Oesophagoscopy
Of autopsy: Confirmatory of above cause of death

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C. L. Owens M.D.
M. D. or other

Address: Cumberland Md Date signed: Oct 9-39

DR. C.L.OWENS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09603

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Hyndman Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ethel Beals

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1918

8. AGE: Years: 21 | Months: 8 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: For Father

FATHER
12. Name: William Beals
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Dorothy Schilling
15. Birthplace: Pennsylvania

16. Informant: William S. Beals.
Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct. 21 1939 (month) (day) (year)

Cemetery or crematory: Hyndman Penna.
Location: Hyndman Penna.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman, Penna.

19. Oct. 19 39 (Date rec'd by registrar) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18, 1939, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1st 1939, to Oct. 18 1939, and that I last saw h ER alive on Oct. 18 1939.

Immediate cause of death	DURATION
Acute purulent pricarditis	10 day
Due to Rheumatic Heart Disease	20 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A. Tapper M.D. M. D. or other
Address: Hyndman Pa Date signed 10-18-39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

09604

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Allegany Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Da.

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. Allegany Hosp. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Baby Girl Bennett - Twin #1

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Fem.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1939

8. AGE: Years 0 | Months 0 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Cumberland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Boyd Bennett

13. Birthplace Cumberland, Md.

MOTHER

14. Maiden Name Ethel Heath

15. Birthplace Binghamton, N. Y.

16 (a) Informant Mr. Boyd Bennett

(b) Address 429 Central Ave. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1939 (month) (day) (year)

(c) Cemetery or crematory Fairview Cem.

Location Near Artemus Penna.

18 (a) Funeral director J. C. Wolford

(b) Address Cumberland

19 (a) Oct. 2, 1939 (Date rec'd by registrar) (b) J. C. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Oct 2 1939, at 1:P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1939, to Oct 2 1939, and that I last saw him or alive on Oct 2 1939.

Immediate cause of death Broncho-pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. B. Barrow M.D. M. D. or other

Address 122 Bedford St Date signed Oct 2, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-A)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

09605

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 151 Center

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 151 Center
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Frances Susan Bennett

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Wm S. Bennett

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 16 — 1858

8. AGE: Years: 80 | Months: 11 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Winchester, Va
(Town, county, and state)

10. Usual occupation: house wife

11. Industry or business:

FATHER
12. Name: S. S. Wilson
13. Birthplace: Va.

MOTHER
14. Maiden name: Rebecca Baumgardner
15. Birthplace: Va.

16. Informant: Victor Bennett
Address: College Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 8-1939 (month) (day) (year)

Cemetery or ~~cemetery~~: Allegany

Location: Frostburg

18. Funeral director: J. J. Dufort

Address: Frostburg Md

19. 10-8 (Date rec'd by registrar) 19 39 Registrar: mrs. A. R. Walker

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1939, at 2.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1938 to Oct 6 1939, and that I last saw her alive on Oct 6 1939

Immediate cause of death: Intestinal Obstruction — DURATION: 3 Days

Due to: Carcinoma of Left Kidney — DURATION: 1 1/2 yrs

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D.
M. D. or other

Address: Frostburg Md Date signed: Oct 7 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 2 1933
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

09606

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH
County: Allegany
City or town: North Branch
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: --
Stay in hospital or insl. (yrs., or mos., or days): --
Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: North Branch Ward No.:
(If ontside city or town limits, write RURAL NEAR and give town)
Street No.: ---
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME ELIZABETH BLOSS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B (b) Name of husband or wife: ### Stephen Bloss
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 5, 1852

8. AGE:

Years	Months	Days	If less than one day
87	0	0	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Bloss
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Louis Bloss
Address: North Branch, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof October 8, 1939 (month) (day) (year)
Cemetery or crematory: Davis Memorial Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Oct. 7 1939 (Date rec'd by registrar) J. S. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1939, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1939, to Oct 5 1939
and that I last saw h-- alive on Oct 4 1939

Immediate cause of death: Arteriosclerosis — DURATION: 3 Yrs.
Due to: Myocarditis
Due to:
Other conditions: Chronic Nephritis
(Includa pregnancy within 3 months of deatb)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): No
Means of injury: Injured at work?

23. SIGNATURE: W. B. Owens M. D. or other
Address: 33 Va Date signed: Oct 6 39

Owens

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

09607

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 133 Potomac St

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 133 Potomac (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mrs Lucy Boone

3. (b) Social Security Number none

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George W. Boone

6(c) If alive, give age about 68 years

7. Birth date of deceased (mo., day, yr.) December 30 - 1872

8. AGE: Years 66 Months 9 Days 21 If less than one day ___ hrs. ___ min.

9. Birthplace West Va (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Conrad

13. Birthplace West Va

MOTHER 14. Maiden name Rose Brock

15. Birthplace West Va

16. Informant Geo W. Boone

Address Cumberland, Md.

17. Hillcrest Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22-39 (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland Md.

18. Funeral director V. L. Lemberan

Address Cumberland Md

19. Oct. 23, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 21 - 1939, at 5:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 1939, to Oct. 21 1939, and that I last saw her alive on Oct. 21 1939

Immediate cause of death Chronic nephritis Arteriosclerosis

DURATION 1935

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Gleason MD M.D. or other

Address 126 Union St. Cumberland Md Date signed 10/23/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

09608

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Bowmans Addition
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Bowmans Addition
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Grace Greenwood Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Thomas E. Brown
6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. January 13, 1879

8. AGE: Years	Months	Days	If less than one day
60	9	7	hrs. min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At home

FATHER
12. Name Henry C. Hensel
13. Birthplace Germany

MOTHER
14. Maiden name Alice Bell
15. Birthplace Maryland

16. Informant Thomas E. Brown
Address Corrigansville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22, 1939 (month) (day) (year)
Cemetery or crematory Greenmont Cemetery
Location Cumberland, Maryland
16. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19 Oct. 21, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1939, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1939 to Oct 20 1939, and that I last saw h alive on Oct 20 1939.

	DURATION
Immediate cause of death Diabetes Mellitus	about 3 yrs.
Due to	
Due to	
Other conditions Arteriosclerosis Myocarditis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide NW Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. K. B. Owens M. D. or other
Address 133 Va Ave Date signed Oct 24 1939

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94C)

09609

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: B. & O. Y.M.C.A.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 130 Oak Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Harry E. Chase

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Holbrok

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1874

8. AGE: Years: 65 Months: 1 Days: 8 If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Street Department

11. Industry or business: City of Cumberland

FATHER

12. Name: Cornelius Chase

13. Birthplace: " New York

MOTHER

14. Maiden name: Unknown Adelaide Lloyd

15. Birthplace: " Virginia

16. Informant: Mr. Edger R. Chase

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 18, 1939 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Oct. 17 1939 J. P. Franklin, M. D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16th., about 1939, at 7.35 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____elive on ____ 19____.

Immediate cause of death: Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ----

Of autopsy: none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Linnie H. Corson, M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 10/16/39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1933
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 — 09610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 36 Elder St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 14 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 36 Elder St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Margaret Cook

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife: Joseph Ramey

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mo + day unknown. 1845

8. AGE:

Years	Months	Days	If less than one day
94	—	—	hrs. min.

9. Birthplace: Moorfield, Hardy, W. Va. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home.

FATHER

12. Name: Jacob Cook

13. Birthplace: Moorfield W. Va.

MOTHER

14. Maiden name: Judy Blackwell

15. Birthplace: Unknown.

16. Informant: Charles Cook

Address: 36 Elder St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1939 (month) (day) (year)

Cemetery or crematory: Baldwin Cemetery

Location: Moorfield W. Va.

18. Funeral director: Jacob Hafer

Address: Cumberland Md.

19. Oct. 30 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

M. E. B. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 1939, at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1939, to Oct 28 1939, and that I last saw h[illegible] alive on Oct 28 1939

Immediate cause of death	DURATION
Arteriosclerosis	about 2 hrs.
Due to: Chronic Myocarditis	2 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. E. B. Owens M. D. or other

Address: 133 Va Ave Date signed: 10/30/39

RECEIVED
NOV 7 1938
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (95-C)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

09611 9

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 81 Bowery St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 81 Bowery St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Wm Crump Cook

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Cook
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct 6 — 1886

8. AGE: Years: 53 Months: — Days: 14 If less than one day ____ hrs. ____ min.

9. Birthplace: Moscow Md (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: General Merchandise

FATHER
12. Name: Wm H. Cook
13. Birthplace: England

MOTHER
14. Maiden name: Janet Morton
15. Birthplace: Scotland

16. Informant: John Gleeck
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 23-1939 (month) (day) (year)
Cemetery or crematory: Cemetary
Location: Shepardstown WVa

18. Funeral director: J. J. Durst
Address: Frostburg Md.

19. Oct. 20 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20 1939, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on Oct. 20 1939, to — 19 —, and that I last saw him alive on Oct. 20 1939.

Immediate cause of death: Died sudd. clearly Seemed to have acute Cer. diac exhaustion.

Due to: No autopsy.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: J. C. Cohen M. D. or other
Address: Frostburg Md. Date signed: 10-21-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 2 1939
U. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-C)

CERTIFICATE OF DEATH

09612

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Flintstone Rt.#1, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Louise Cooper

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:
B(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 31, 1939

8. AGE: Years: . Months: 2 mos. Days: 28 If less than one day: hrs. min.

9. Birthplace: ~~Maryland~~ Southampton, Pa. (Town, county, and state) Township

10. Usual occupation:

11. Industry or business

FATHER
12. Name: James Cooper,
13. Birthplace: Maryland

MOTHER
14. Maiden name: Opal Ash,
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30 1939 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetary
Location: Flintstone, Md. Route #1,
18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Oct. 29 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. C. L. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29, 1939 at 12:40 AM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8th 1939 to Oct 29 1939, and that I last saw h[er] alive on Oct 29 1939

Immediate cause of death: Congenital Endocarditis

DURATION: Quite

Due to:

Due to:

Other conditions: non closure of foramen ovale Patent ductus Arteriosus Ware Typ 1 Staph Pulete

(Include pregnancy within 3 months of death)

Major findings:
Of operations: no operations
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C L Owens M D
M. D. or other
Address: Cumberland Md. Date signed Oct 29-39

Authorization to change birthplace — see letter filed under Franklin. 11/16/39.

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09613

(131)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 156 N. Mechanic St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Alonzo ~~Alonzo~~ J. Cope

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Emma Furlong Cope

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 5, 1885

8. AGE: Years	Months	Days	If less than one day
54	5	3	____ hrs. ____ min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Musician

11. Industry or business

FATHER
12. Name: Samuel Cope
13. Birthplace: England

MOTHER
14. Maiden name: Carrie Mullin
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 11, 1939 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Oct. 10 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1939, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-14-1938, to 10-8-1939, and that I last saw him alive on 10-8-1939.

Immediate cause of death: Chronic Myocarditis / Chronic Endocarditis — DURATION

Due to: Chronic Nephritis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: Md

DR. W.F.WILLIAMS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

210-m

09614

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Brookfield Avenue (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Paul Cordry

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irma Thomas

6(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): May 19, 1899

8. AGE: Years: 40 Months: 5 Days: 0 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: B. & O. Railroad

FATHER
12. Name: Elijah Cordry
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Cassidy
15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1939 (month) (day) (year)

Cemetery or crematory: ~~St. P. & P.~~ Rose Hill Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Oct. 13, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. ENFIELD

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1939, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8 1939 to Oct 11 1939 and that I last saw him alive on Oct 11 1939

Immediate cause of death: Cardiac Failure

Due to: Fractured skull, humerus ulna Rodeys

Due to: & several ribs.

Automobile accident, October 8th, 1939, on West Virginia Highway, near Dixie, West Virginia. Cwlr.

Other conditions: (Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Oct 8-39

Where did injury occur? Alex Difil (City or town) (County) Ohio (State)

Injured at home, farm, industry, public place (where?): Ohio Highway

Means of injury: Injured at work?

23. SIGNATURE: S. E. Enfield M. D. or other

Address: Cumberland, Md. Date signed: 10/12/39

RECEIVED
OCT 30 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

09615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 7 days.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 703 Maryland Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert Lewis Craze.

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Child

8 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1935

8. AGE: Years 4 Months 3 Days 5 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Chas. F. Craze.
13. Birthplace Midland Md.

MOTHER
14. Maiden name Ruth Josephine Walker
15. Birthplace Cumberland, Md.

16. Informant Mrs Ethel Walker
Address 703 Md. Ave. Cumberland, Md

17. Burial Date thereof Oct 7, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland Md.

18. Funeral director Jacob Hafer
Address Cumberland, Md

19. Oct. 7, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

M. E. B. Owens.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1939, at 5.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1939, to Oct 5 1939, and that I last saw him alive on Oct 5 1939.

Immediate cause of death: Tuberculous Meningitis

DURATION: Sev

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E B Owens
M. D. or other

Address 133 Va Ave Date signed Oct 7 '39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

M.E.B Divers

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

09616

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days) 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. RD#2, Williams Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eva Marie Davis

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

ok

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March ~~28~~, 1939

8. AGE: Years 0 Months 6 Days 17 If less than one day hrs. min.

9. Birthplace Cumberland, Maryland

(Town, county, and state)

10. Usual occupation --

11. Industry or business --

FATHER

12. Name Harvey W. Davis

13. Birthplace Maryland

MOTHER

14. Maiden name Eva E. Close

15. Birthplace Maryland

16. Informant Mr. Harvey W. Davis

Address Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 17, 1939 (month) (day) (year)

Cemetery or crematory Mt. Herman Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Oct. 17, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-39 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-~~4~~-39 19 , to 10-15-39 19 , and that I last saw her alive on 10-14-39 19 .

Immediate cause of death 2nd & 3rd degree burns about head & left arm

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Oct 4-39

Where did injury occur? ~~Hedgely, Wet. Va.~~ Cumb. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Burn Injured at work?

23. SIGNATURE W. Alfred Van Dines M. D. or other

Address Cumb. Md. Date signed 10-16-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

A-09617

Reg. Dist. No. 9-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg – Delaysville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: National Highway

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg-Rural Clarysville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. National Highway
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Wm Delaney

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of husband or wife: Rachel Delaney

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 14 – 1860

8. AGE:

Years	Months	Days	If less than one day
79	9	15	hrs. min.

9. Birthplace: Vale Summit
(Town, county, and state)

10. Usual occupation: retired laborer

11. Industry or business: Bus Co

FATHER 12. Name: Patrick Delaney

13. Birthplace: Ireland

MOTHER 14. Maiden name: Mary Cain

15. Birthplace: Ireland

16. Informant: Mrs Bernard Maslin

Address: Clarysville, Md.

17. St Michaels (Burial, cremation, or removal? Which?) Date thereof: Oct 31-1939 (month) (day) (year)

Cemetery or crematory: St Michaels

Location: Frostburg

18. Funeral director: J J Walsh

Address: Frostburg

19. Oct. 30 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1939, at 6 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1937 to Oct 27 1939 and that I last saw h[illegible]live on Oct 28 1939

Immediate cause of death	DURATION
Cardiac Dilatation	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:

Ot operations:

Ot autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J A Delany M. D. or other

Address: Frostburg Md Date signed: 10-20-39

RECEIVED
NOV 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106d)

09618

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 647 North Mechanic St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 647 North Mechanic St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: ANNIE BUTLER EDWARDS

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Richard N. Edwards

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December, 1857

8. AGE: Years: 81 Months: 9 Days: ? If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Margaret Butler
15. Birthplace: Maryland

16. Informant: Mrs. Irene Haller
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 8, 1939 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Oct. 7 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1939, at 3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23, 1939, to Oct. 4th 1939, and that I last saw her alive on Oct. 4 1939.

Immediate cause of death: Edema of the Lungs

Due to: Bronchitis, Pharyngitis

Due to: Senile Asthenia

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Hollomand M.D.
M. D. or other

Address: 145 Hanover St. Date signed: Oct. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46-C)

09619

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 624 N. Mechanic St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 59 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 624 N. Mechanic St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Gerard Everstine

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma Zihlman

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 1880

8. AGE: Years 59 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Cumberland Allegany Co Md.
(Town, county, and state)

10. Usual occupation Insurance agent

11. Industry or business

FATHER
12. Name G. Jos. Everstine
13. Birthplace Md.

MOTHER
14. Maiden name Ella Hammond
15. Birthplace Pa.

16. Informant Ella Everstine

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 '39 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. Oct. 20 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1939 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1939 to Oct 18 1939, and that I last saw him alive on Oct 17 1939.

Immediate cause of death Carcinomatosis

Due to Carcinoma of Sigmoid

Due to Primary carcinoma of sigmoid flexure. Duration: Eighteen months [illegible]

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Carcinoma of liver sigmoid + [illegible]

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Crofield M. D. or other

Address Cumberland Date signed Oct 19 '39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

09620

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Ridgeley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Flanagan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 11 - 1939

8. AGE:

Years	Months	Days	If less than one day
			7 hrs. 10 min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Raul Amos Flanagan
13. Birthplace Elkins W. Va.

MOTHER
14. Maiden name Lillian Ruth Smith
15. Birthplace Ridgeley W. Va

16. Informant Mrs. Lillian Flanagan
Address Ridgeley W. Va.

17. Burial. Date thereof Oct. 11, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Carpenters Addn.

Location Ridgeley W. Va.

18. Funeral director Paul A. Flanagan

Address Ridgeley, W. Va.

19. Oct. 11 1939 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1939, at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11 1939, to Oct. 11 1939, and that I last saw her alive on Oct. 11 1939.

Immediate cause of death	DURATION
Prematurity (About 24 wks gestation)	10-11-39
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. Jones M.D.
M. D. or other

Address 402 N. Liberty St. Date signed 10-11-39

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (50)

Reg. Dist. No. 5

09621

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Rawlings R.F.D. 4 (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____ (If outside city or town limits, write RURAL and give town)

(d) Street No. ____ (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Tyre Orpha Flanagan.

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ D. Grover Flanagan

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) ✓

8. AGE: Years 40 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace West Va (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Porter Corner
13. Birthplace W. Va

MOTHER
14. Maiden Name Eliza Long
15. Birthplace W. Va

16 (a) Informant D. Grover Flanagan

(b) Address Keyser R.F.D. 4.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-39 (month) (day) (year)

(c) Cemetery or crematory Waxler Cem.

Location Near Rawlings, Md. R.F.D.

18 (a) Funeral director V. L. Lemperer

(b) Address Cumberland, Md.

19 (a) 10/9-9 (Date rec'd by registrar) (b) M. J. Tummeti Registrar

MEDICAL CERTIFICATION

20. Date of death Oct 6th 1939, at 7.45p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1939, to Oct 6 1939, and that I last saw him alive on Oct 6 1939.

Immediate cause of death Carcenoma Breast — Duration 2 yrs

Due to ____

Due to ____

Other conditions ____ (Include pregnancy within 3 months of death)

Major findings:
Of operations Breast Removed Feb. 1939
Of autopsy ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) ____ (County) ____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____

(e) Means of injury ____

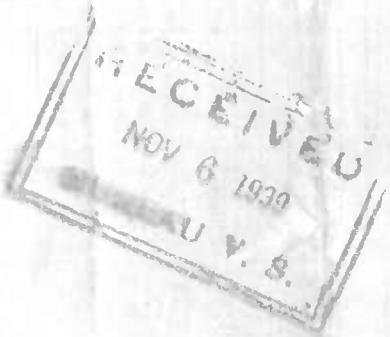
23. Signature E. A. Courrier M. D. or other

Address Keyser W. Va Date signed 10-7-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
NOV 6 1939
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

CERTIFICATE OF DEATH

09622

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: B. & O. Railroad Tracks
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 313 Central Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Howard M. Francis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife: Ada --?--

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 28, 1879

8. AGE: Years	Months	Days	If less than one day
60	8	16	hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Window Washer

11. Industry or business: --

FATHER
12. Name: Nicholas Francis
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Francis
15. Birthplace: Maryland

16. Informant: Walter Edwards
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 17, 1939 (month) (day) (year)
Cemetery or crematory: Sumner Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19 Oct. 17 1939 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

MEDICAL CERTIFICATION

Probably

20. DATE OF DEATH: October 13th., 1939, at ---- M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---- 19---, to ---- 19---, and that I last saw h--- alive on ---- 19---

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Prince H. Brown M. D.
M. D. or other
Address: Cumberland, Maryland Date signed 10/16/39

Deputy Medical Examiner - Allegany Co.

RE... ED
OCT 24 ...
BUREAU V. L...

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (73-2) Reg. Dist. No. 6

CERTIFICATE OF DEATH

09623

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Westernport (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 434 Hammond Street

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 28 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Westernport, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 434 Hammond St. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Margaret Anna Garritano

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alphonse Garritano

6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 19, 1886

8. AGE: Years 53 | Months 2 | Days 19 | If less than one day 11 hr. ____ min.

9. Birthplace Eckhart, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Thomas Walkoviak

13. Birthplace Berlin Germany

MOTHER

14. Maiden Name Hatti Lipchinski

15. Birthplace Berlin, Germany

16 (a) Informant Alfonso Garritano

(b) Address 434 Hammond St., Westernport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 9 1939 (month) (day) (year)

(c) Cemetery or crematory St Peters

Location Westernport, Md.

18 (a) Funeral director W. S. Boyle

(b) Address Barton, Md.

19 (a) Oct. 9. 1939 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death 10-6 1939, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1938, to 10-6 1939, and that I last saw him alive on 10-6 1939.

	Duration
Immediate cause of death Cerebral Thrombosis	6 days
Due to Chronic Nephritis	9
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature] M. D. (M. D. or other)

Address Westernport Md Date signed 10/7/39

RECEIVED
NOV 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

09624

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. JACOBSON

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town ACCIDENT Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
MRS. FLORA CATHERINE GIES

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife MR. NEWTON GIES

6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name JEREMIAH BITTNER

13. Birthplace MARYLAND

MOTHER 14. Maiden name MARY BOWMAN

15. Birthplace MARYLAND

16. Informant NEWTON GIES

Address ACCIDENT, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-2 1939 (month) (day) (year)

Cemetery or crematory cemetary

Location accident Md

16. Funeral director Allen Winterberg

Address Grantsville Md

19. Oct. 31, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

I;I5

20. DATE OF DEATH OCTOBER 31, 1939 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29 1939, to October 31 1939, and that I last saw h[illegible] alive on October 31 1939.

	DURATION
Immediate cause of death Uremia Coma	3 days
Due to Diabetes Mellitus	? ?
Due to Chronic Nephritis	? ?
Myocardosis	? ?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M.D. M. D. or other

Address 119 Baltimore St Date signed 10/31/39
Cumberland, Md.

RECEIVED
NOV 9 1920
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61-a)

CERTIFICATE OF DEATH

09625

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 408 Cedar St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Girl Grapes - Twin #1

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: None
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 6, 1939

8. AGE: Years	Months	Days	If less than one day
2 days			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Elmer Grapes
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Evelyn McCrea
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10-39 (Month) (day) (year)
Cemetery or crematory: Mt. Hope Cem
Location: Mt. Hope, Penna.
18. Funeral director: U. L. Lemmerman
Address: 202 Green St - Cumberland Md
19. Oct. 9, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. REYNOLDS

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1939, at 7:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6/39 19 to Oct 8 1939, and that I last saw h alive on Oct 8/39 19

Immediate cause of death	DURATION
Congenital atelectasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Knight Reynolds M.D.
M. D. or other
Address: Cumberland Md Date signed Oct 9/39.

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98-C)

CERTIFICATE OF DEATH

096269

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg Md.
(If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution: Borden Road.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL, NEAR and give town)
Street No. 129 Pine St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Elizabeth Strube Harlig

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Phillip Harlig Sr.
6(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): Nov 11 1872
8. AGE: Years: 68 Months: 10 Days: — If less than one day: hrs. min.
9. Birthplace: Frostburg Allegany, Md. (Town, county, and state)
10. Usual occupation: House wife.
11. Industry or business: None.
FATHER 12. Name: Wm Strube
13. Birthplace: Germany
MOTHER 14. Maiden name: Anda Marie Eisler
15. Birthplace: Germany.
16. Informant: Phillip Harlig Sr.
Address: 129 Pine St - Frostburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16, 1939 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: Isaac D. Walker
Address: Frostburg, Md.
19. 10-16 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13 1939, at 9:00 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1 1939 to Oct 13 1939, and that I last saw h-er alive on Oct 13 1939.

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 wks
Due to: Atrom Myocarditis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: no
Of autopsy: no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. O. McLandress M.D. (M.D. or other)
Address: Frostburg Md. Data signed: Oct 16 1939

RECEIVED
NOV 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-E)

09627

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 412 South Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Charles E. House

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ~~Rose~~ Ratke Rosella M.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): ~~Se~~ Jan. 19, 1895

8. AGE: Years 44 Months 9 Days 0 23 If less than one day ____ hrs. ____ min.

9. Birthplace: Brunswick, Maryland (Town, county, and state)

10. Usual occupation: Yardmaster

11. Industry or business: B. & O. Railroad

FATHER

12. Name: Charles W. House

13. Birthplace: Mineral Co., W. Va.

MOTHER

14. Maiden name: ~~Mary Lark~~ Lula Jenkins

15. Birthplace: Mineral Co., W. Va.

16. Informant: Mrs. Ruth Umstot

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 16, 1939 (month) (day) (year)

Cemetery or crematory: St. P. & P. Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Oct. 13, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1939, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1/39 19 to 10/12 1939, and that I last saw him alive on 10/12/39 19

Immediate cause of death: Cirrhosis / liver with ascites

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: John K Rozman M D M. D. or other

Address: Cumberland Md Date signed 10/12/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Authorization to change items #6 & 14, letter filed under Dr. John Rozum, 11-6-39 in Permanent File.

RE[illegible]ED
OCT. 24 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93C)

CERTIFICATE OF DEATH

09628

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
917 Glenwood St

Stay in hospital or Insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 917 Glenwood St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna M Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Richard Jones

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 1874

8. AGE: Years 62 | Months 4 | Days 20 | If less than one day hrs. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Marian Tipps

13. Birthplace Ohio

MOTHER 14. Maiden name Elizabeth Tinker

15. Birthplace Ohio

16. Informant Richard Jones

Address 917 Glenwood St City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23, 1939 (month) (day) (year)

Cemetery or ~~crematory~~ Asbury Mt Ro

Location Hardy Co W Va

18. Funeral director W H McKee

Address Augusta W Va

19. Oct. 23, 1939 (Date rec'd by registrar) J. I. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1939 AT M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1939 to Oct 20 1939

and that I last saw h alive on Oct 1 1939

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	2 months
Due to	
Other conditions Asthenia	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Wm Franklin M. D. or other

Address Date signed Oct 21 1939

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

09629

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution 1103 Oldtown Road.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany.
City or town Cumberland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1103 Oldtown Road.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lillie Dale Smith Jones.

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: James Jones
6(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): June 4, 1879
8. AGE: Years: 60 Months: 9 Days: 16 If less than one day: hrs. min.
9. Birthplace: Flats, Hardy Co., W. Va.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: At Home.
FATHER 12. Name: George Smith.
FATHER 13. Birthplace: Flats W. Va.
MOTHER 14. Maiden name: Sarah A. Williams.
MOTHER 15. Birthplace: Liverpool England
16. Informant: James Jones
Address: 1103 Oldtown Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22, 1939 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery.
Location: Cumberland Md.
18. Funeral director: Jacob Hafer
Address: Cumberland Md.
19 Oct. 21, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1939 9.40 at A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__

Immediate cause of death: Accidental drowning in bath-tub of her home — DURATION

Due to

Due to

Other conditions: Weak, debilitated, chronic invalid — 20 Yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: No autopsy.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10/20/39
Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): At home.
Means of injury: Drowning Injured at work? No.

23. SIGNATURE Prince H. Lowry, M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed 10/21/1939

Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94E)

09630

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 187 Thomas Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 187 Thomas Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Clara Mary Kelley

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Thomas Kelley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1867

8. AGE: Years 72 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name Elliath Judy

13. Birthplace Maryland

MOTHER 14. Maiden name Anna Witter

15. Birthplace Frederick, Md.

16. Informant Miss Hope Kelley

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 18, 1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Oct. 17, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1939, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I ~~attended~~ never attended deceased from 19 , to 19 ,

and that I ~~last~~ never saw her alive on 19 .

Immediate cause of death (Dead on arrival)

DURATION

Due to Coronary Thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Durrett M. D. or other

Address Cumberland, Md. Date signed Oct. 16, 1939

RECEIVED
NOV 7 1939
BUREAU V. S.

Outside of City Limits

09631

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94b)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: RFD 3, Hazen Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: RFD 3, Hazen Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Annie E. Kirby

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. F. Kirby

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 2, 1855

8. AGE: Years 84 | Months 2 | Days 24 | If less than one day ____ hrs. ____ min.

9. Birthplace: Elkhard, Maryland, Allegany Co.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER

12. Name: Robert C. Paul

13. Birthplace: Maryland

MOTHER

14. Maiden name: Annie E. Miller

15. Birthplace: Maryland

16. Informant: Mr. George L. Kirby

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 29, 1939 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Oct. 28, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26, 1939, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26, 1939, to Oct. 26, 1939, and that I last saw h____ alive on ____ 19____

Immediate cause of death: Coronary Thrombosis (Pronounced Dead)

DURATION: Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Clay E. Durrett M. D. or other

Address: Cumberland Date signed: Oct. 27, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

09632

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 921 Lexington Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: HARRY KOEGLE

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: (?) (Not married)
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): ???
8. AGE: Years: 70 Months: ????? Days: ???? If less than one day: hrs. min.
9. Birthplace: ??? (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business
FATHER 12. Name: ???
13. Birthplace
MOTHER 14. Maiden name: ???
15. Birthplace
16. Informant: Allegany Hospital, Cumberland, Maryland
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 18, 1939 (month) (day) (year)
Cemetery or crematory: Allegany County Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Oct. 17, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1939, at 3:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 1939, to October 16 1939, and that I last saw him alive on October 16 1939.
Immediate cause of death: Coronary thrombosis — DURATION: 1 hour
Due to: Myocarditis c̄ cardiac decompensation c̄ Extrasystoles
~~Due to~~ Chronic Nephritis. Chronic Prostatis.
Other conditions
(Include pregnancy within 8 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Samuel Jacobson M.D. M. D. or other
Address: 119 Bedford St. Date signed: 10/16/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

09633

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1
Stay in this community (yrs., or mos., or days): 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Flintstone Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Harry J. Krumbine

3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Cora Winters Krumbine
6(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): June 11, 1893
8. AGE: Years: 54 Months: 4 Days: 3 If less than one day: hrs. min.
9. Birthplace: Martinsburg W Va. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Contractor
FATHER 12. Name: Henry D. Krumbine
FATHER 13. Birthplace: Martinsburg W. Va.
MOTHER 14. Maiden name: Virginia Billis.
MOTHER 15. Birthplace: Pennsylvania.
16. Informant: Clarence Krumbine
Address: Flintstone Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 16, 1939 (month) (day) (year)
Cemetery or crematory: Bible Cem.
Location: Flintstone Md
18. Funeral director: Jacob Hafer
Address: Cumberland Md
19. Oct. 16, 1939 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 1939, 5:34 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1939 to Oct 14 1939, and that I last saw him alive on Oct. 14 1939.

	DURATION
Immediate cause of death: Diabetic Coma	Oct. 13 1939
Due to: Diabetic Mellatus	14 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos. H. Koon M. D. or other
Address: Cumberland Md Date signed:

Dr Koon

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

09634

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County ALLEGANY COUNTY

City or town CUMBERLAND

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

906 OLDTOWN RD.

Stay in hospital or inst. (yrs., or mos., or days) 11 DAYS

Stay in this community (yrs., or mos., or days) 53 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 906 OLDTOWN RD.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME LAPP, MARY ELIZABETH MRS.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife LAPP, HENRY

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) AUGUST 29 1864

8. AGE: Years	Months	Days	If less than one day
75	1	21	hrs. min.

9. Birthplace MARYLAND Cumberland (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name HANDEL, JACOB

13. Birthplace GERMANY

MOTHER

14. Maiden name BARNHART? CHRISTINE

15. Birthplace MARYLAND Cumberland

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23 1939 (month) (day) (year)

Cemetery or crematory Hillcrest

Location Cumberland

18. Funeral director Jacob Lefer

Address Cumberland

19 Oct. 21 39 J. L. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/39 19 at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/16/39 19 to 10/20/39 19, and that I last saw her alive on 10/19/39 19.

Immediate cause of death	DURATION
Chr Myocarditis	
Chronic Arteriosclerosis	
Due to Interstitial Pneumonia	
Chr Nephritis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard L. Williams M.D. M. D. or other

Address 34 Va. Ave. Date signed 10/20/39

Cumberland, Md.

DR. R. WILLIAMS

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

09635

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days) 24 Days

Stay in this community (yrs., or mos., or days) 25 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL NEAR and give town) Ward No.

Street No. 106 W University Parkway (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Teresa Lee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 17 - 1872

8. AGE: Years 67 | Months 2 | Days 2 | If less than one day hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Retired School Teacher

11. Industry or business

FATHER 12. Name John Lee

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Mary A Sinclair

15. Birthplace Baltimore Md

16. Informant Wm C Lane Jr M D

Address Frostburg Md

17. (Burial, cremation, or removal. Which?) Date thereof aug 21-1939 (month) (day) (year)

Cemetery or crematory New Cathedral Cem.

Location Baltimore

18. Funeral director J. J. Durst

Address Frostburg, Md.

19. Oct. 19 1939 (Date rec'd by registrar) mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1939, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1939, to Oct 19 1939, and that I last saw h-er alive on Oct 19 1939

Immediate cause of death	DURATION
Pulmonary Embolus	1 Day
Due to Carcinoma Left Breast	??
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations Carcinoma Left Breast

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm C Lane Jr M D M. D. or other

Address Frostburg Md Date signed Oct 19 1939

RECEIVED
OCT 26 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

09636

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 5337 Orth Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: 5337 Orth Ave Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Cumberland Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Eva Mand Schenck Long.

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Raymond H Long

6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Jan 30. 1883

8. AGE: Years 56 Months 8 Days 20 If less than one day ___ hrs. ___ min.

9. Birthplace: Cumberland, Md (Town, county, and state)

10. Usual occupation: House work at Home

11. Industry or business

FATHER

12. Name: Edward L Schenck.

13. Birthplace: Md

MOTHER

14. Maiden name: Lora A Leasure

15. Birthplace: Penna.

16. Informant: Mr Raymond H Long

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 23, 39 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland Md

18. Funeral director: Louis Stein Ins.

Address: Cumberland Md

19. Oct. 23 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20 1939, at 8 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/27/37 19 ___, to 10/20 1939, and that I last saw her alive on 10/20/39 19 ___.

Immediate cause of death: Carcinomatosis

Due to: Carcinoma of recto sigmoid

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Colostomy

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ___ Injured at work?

23. SIGNATURE: John K Rozum M.D. M. D. or other

Address: Cumberland Md Date signed: 10/21/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

09637

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 725 Williams Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 725 Williams Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ernest MacKenzie

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Edith MacKenzie

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1858.

8. AGE: Years: 80 Months: 10 Days: 14 If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: J. T. MacKenzie
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Greenwade
15. Birthplace: Maryland

16. Informant: Mrs. Edith MacKenzie

Address: 725 Williams Road Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1939 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Oct. 31, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28, 1939, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sudden death, dropped dead, and that I last saw h____ alive on ____ 19____

Immediate cause of death: Angina Pectoris — DURATION: Sudden

Chronic Myocarditis — 1 year

Due to

Due to: Chronic Nephritis — 1 year

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Thos. H. Kraus M. D. or other

Address: Cumberland Md. Date signed

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94?)

CERTIFICATE OF DEATH

09638

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: WEST VIRGINIA County: MINERAL

City or town: RIDGELEY Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Knobley Road
(If rural give LOCATION)

2(a). IF VETERAN, NAME WAR:

3. (a) FULL NAME: MRS. KATHERINE (KATIE) MAIER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife: ADAM MAIER

6(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): DEC. 27, 1869

8. AGE: Years	Months	Days	If less than one day
69	9	16	____hrs. ____min.

9. Birthplace: GERMANY (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER

12. Name: ZETZ, Joseph MR.

13. Birthplace: GERMANY

MOTHER

14. Maiden name: MARY [illegible] Aamner

15. Birthplace: GERMANY

16. Informant: ADAM MAIER

Address: RIDGELEY, W. VA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1939 (month) (day) (year)

Cemetery or crematory: St. P. & P. Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Oct. 13, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. R. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 12, 1939 at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1939 to Oct 12 1939 and that I last saw h- alive on Oct 11 1939

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to Hypertension	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Richard J. Williams M.D. M. D. or other

Address: 34 Van Ave. Date signed: 10/13/39

Cumberland Md

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (201-g)

09639

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reeves Clinic

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Barbara L. Marsh

3. (b) Social Security Number 236-12-4105

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lucy Grigsby Marsh

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1889.

8. AGE: Years 50 Months 0 Days 25 If less than one day ___ hrs. ___ min.

9. Birthplace Madison Co. Virginia (Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business Adam Campbell Coal Mines Broshear

FATHER 12. Name George Marsh

13. Birthplace Virginia

MOTHER 14. Maiden name Virginia Yowell

15. Birthplace Virginia

16. Informant Otis Marsh

Address Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1939 (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Md

18. Funeral director W. H. Friedlock

Address Piedmont, W. Va.

19. Oct. 5 1939 (Date rec'd by registrar) A. J. Gaymbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1939, at 8:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1939, to Oct. 3, 1939, and that I last saw h ___ alive on ___ 19 ___

Immediate cause of death	DURATION
Fracture ribs (7-8-9-10) left chest	10-3-39
Left Pneumothorax	10-3-39
Due to Fracture 3rd Vertebrae	10-3-39
Fracture pelvis	10-3-39
Due to Internal injuries - liver	10-3-39
Other conditions Traumatic shock	"

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-3-39

Where did injury occur? Westernport, Alle. Co. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Adam Campbell Coal Mines

Means of injury Bone coal fell on him Injured at work? Yes.

23. SIGNATURE J. Norman Reeves M.D. M. D. or other

Address Westernport, Md Date signed 10-5-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

09640

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 14 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Cresaptown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
MARTIN, GRACE MISS

3. (b) Social Security Number
217-10-5856

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 10 1895

8. AGE: Years	Months	Days	If less than one day
44	6	17	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation Celenese Corp.

11. Industry or business Spinner

FATHER
12. Name MARTIN, HENRY
13. Birthplace MARYLAND

MOTHER
14. Maiden name ORNDORFF, MARY ELIZABETH
15. Birthplace ~~XXXX~~ VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 '39 (month) (day) (year)

Cemetery or crematory Episcopal Cem.

Location Mt Savage, Md.

18. Funeral director Lewis Stein Inc.

Address Cumberland.

19. Oct. 30, 39 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

Dr. G. Cowherd

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1939, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1939, to Oct. 27 1939, and that I last saw h~~e~~r alive on Oct 27 1939.

Immediate cause of death	DURATION
Uremia	
Due to Carcinoma of uterus	2yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Gomett Cowherd M. D. or other

Address Cumberland Date signed Oct 27-39

RECEIVED
NOV 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

09641

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg (Rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Wrights Crossing

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Wrights Crossing
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Baby McVeigh

3. (b) Social Security Number —

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Infant

6 (b) Name of husband or wife Infant

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 2 1939

8. AGE: Years | Months | Days 1 | If less than one day ____ hrs. ____ min.

9. Birthplace Frostburg Md
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Hugh Daniel McVeigh
13. Birthplace Midland, Md

MOTHER
14. Maiden name Lottie Laverne Loan
15. Birthplace Vale Summit, Md

16. Informant Hugh Daniel McVeigh
Address Wrights Crossing

17. ____ (Burial, cremation, or removal. Which?) Date thereof 10 - 4 39 (month) (day) (year)

Cemetery or crematory St. Michaels Cem.

Location Frostburg Md.

18. Funeral director Hugh Daniel McVeigh

Address Frostburg Md.

19. 10-4 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1939, at 8:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1939, to Oct 3 1939, and that I last saw him alive on Oct 3 1939.

Immediate cause of death Prematurity

DURATION 1 Day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE W. M. McLane Jr. MD
M. D. or other

Address Frostburg Md Date signed Oct 3 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110)

CERTIFICATE OF DEATH

09642

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 7 days
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Flintstone Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Thomas Mihailovich

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Florence Grajson
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
45			hrs. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: George C. Frey's Farm
FATHER 12. Name: Peter Mihailovich
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: "
MOTHER 15. Birthplace: "
16. Informant: Willard Mihailovich
Address: Flintstone, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 29, 1939 (month) (day) (year)
Cemetery or crematory: Robinette Cemetery
Location: Flintstone, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Oct. 29 39 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1939, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1939 to Oct. 27 1939, and that I last saw him alive on Oct. 27, 1939.

Immediate cause of death: Empyema right chest — DURATION: 24 da
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings: Of operations: Pus in right pleura cavity.
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J. P. Franklin M. D. or other
Address: Cumberland Md. Date signed: 10/28/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 7 1930
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (51-C)

CERTIFICATE OF DEATH

0964310
Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: -- at home --
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 75 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: ---
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Francis Joseph Miller

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ella Kane Miller
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 23, 1864
8. AGE: Years 75 | Months 2 | Days 3 | If less than one day: hrs. min.
9. Birthplace: Mt. Savage, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Pattern maker
11. Industry or business: C. & P. Railroad
FATHER 12. Name: Unknown
13. Birthplace: "
MOTHER 14. Maiden name: "
15. Birthplace: "
16. Informant: Vincent Miller
Address: Mt. Savage, Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof: October 30, 1939 (month) (day) (year)
Cemetery or crematory: St. Patrick Cemetery
Location: Mt. Savage, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Oct. 29 1939 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1939, at 3:00 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1939, to Oct 26 1939 and that I last saw him alive on Oct 26 1939.
Immediate cause of death: Cancer of rectum
Due to: Metastasis from Carcinoma of prostate
Due to: Prostatectomy Apr 22-37
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: Carcinoma of prostate
Of autopsy:

DURATION: 6 mos

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. W. Trevaskis, M.D. M. D. or other
Address: Cumberland, Md Date signed: Oct 28-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 2 1 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

09644

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Oldtown R. D. #1.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Oldtown R. D. #1.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown R. D. #1. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Oldtown R. D. #1.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Nona Selinda Miller

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Paul E. Miller

6(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): Dec. 18, 1902

8. AGE:

Years	Months	Days	If less than one day
36	10	0	____ hrs. ____ min.

9. Birthplace: Oldtown, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Talbert Stallings
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Stallings
15. Birthplace: Maryland

16. Informant: Mr. Paul E. Miller
Address: Oldtown R.D. #1. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20, 1939 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cem.

Location: Near Oldtown Maryland.

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Oct 20 1939 (Date rec'd by registrar) Mo. C. Shankle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18, 1939, at 4A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18 to October 18 1939, and that I last saw her alive on October 18 1939.

Immediate cause of death	DURATION
Bronchial Asthma	36 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. J. Bro. Dup. M. D. or other

Address: Cumberland, Md. Date signed 10-19-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 8 1939
BUREAU U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09645

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): none

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Mineral

City or town: Keyser Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 39 N. Mineral St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Boy Minter (Stillborn)

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Ocrober 16, 1939

8. AGE: Years: 0 Months: 0 Days: 0 If less than one day: 0 hrs. 0 min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Stewart Minter
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mildred Oswald
15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Oct. 17, 1939
(month) (day) (year)

Cemetery or crematory: Luthern Cem.

Location: Bedford Road

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Oct. 17, 1939 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

DR. J.K. COWHERD

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1939, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/16/39 19 to 10/16/39 19 and that I last saw him alive on 10/16/39 19

Immediate cause of death: Premature separation of Placenta (7 1/2 mths)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: J. K. Cowherd, M. D.
M. D. or other

Address: 41 Green St. Cumberland, Md. 10/17/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

09646

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 1418 River Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1418 River Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Howard Moreland

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Inskeep

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 58 Months: Days: If less than one day: hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Grocer

11. Industry or business: Own grocery

FATHER
12. Name: James H. Moreland
13. Birthplace: Unknown

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Mrs. Bessie Moreland
Address: Cumberland, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 31, 1939
(month) (day) (year)
Cemetery or crematory: Wesley Chapel Cemetery
Location: Points, West Virginia

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19 Oct. 31 19 39 (Date rec'd by registrar)

J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/29/39 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23/39 19 to 10/29/39 19 , and that I last saw h alive on 10/29/39 19

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Chronic Nephritis	
Due to: [illegible]	
Other conditions: Varicose Ulcers.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard J. Williams M.D.
M. D. or other
Address: 34 Va. Ave., Cumberland
Date signed: 10/30/39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (81)

Reg. Dist. No. 4

09647

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County: Allegany
(b) City or town: Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 15 Prospect Square
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in this community (yrs., mos., or days): 15 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State: Md. (b) County: Allegany
(c) City or town: Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Prospect Square (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME: Taylor Morrison

3 (b) If veteran, name war: —
3 (c) Social Security No.: —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maude L. Morrison
6 (c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): July 4, 1872
8. AGE: Years: 67 Months: 3 Days: 27 If less than one day: ____ hr. ____ min.
9. Birthplace: Alexandria, Virginia (Town, county, and state)
10. Usual occupation: Lawyer
11. Industry or business:
FATHER 12. Name: James Morrison
13. Birthplace: New Baltimore, Va.
MOTHER 14. Maiden Name: Esther Rebecca Clark
15. Birthplace: Alexandria, Va.
16 (a) Informant: Martha Morrison
(b) Address: Westernport Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2, 1939 (month) (day) (year)
(c) Cemetery or crematory: Morrison's Cem.
Location: Near Barton, Morrison
18 (a) Funeral director: D. S. Beal
(b) Address: Barton Md.
19 (a) Nov. 1, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death: October 30, 1939, at 5:50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1939, to Oct 30 1939, and that I last saw him alive on Oct 30 1939.

	Duration
Immediate cause of death: Diarrhea	2 weeks
Due to: Sytalitic (confirmed) Sclerosis of the Cord	1 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: F. W. Taylor M. D. (M. D. or other)
Address: Cumberland Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131) Reg. Dist. No. 10

09648

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Mt Savage (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 65yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Mt Savage (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Catherine Elizabeth Mullan.

3 (b) If veteran, name war
3 (c) Social Security No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Wm Mullan.
6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 1873.

8. AGE: Years 66 | Months 7 | Days 11 | If less than one day ____hr. ____min.

9. Birthplace Mt Savage Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home

FATHER
12. Name Thomas Mullegan.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Bridget Farrell.
15. Birthplace Ireland.

16 (a) Informant Wm Mullan.
(b) Address Mt Savage Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 1939 (month) (day) (year)
(c) Cemetery or crematory St Patricks Cemetery
Location Mt Savage Md
18 (a) Funeral director Young Sisters Inc.
(b) Address Cumberland Md.
19 (a) Oct 17 39 (Date rec'd by registrar) (b) A J Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Oct. 13 1939, at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10 1939, to Oct 13 1939, and that I last saw him alive on Oct 12 1939.

Immediate cause of death Cerebral Hemmorrhage. Hypertension. Chronic Nephritis
Due to Myocardial Insufficiency.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A J Bostetter M.D. M. D. or other
Address Mt Savage Md Date signed 10/14/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 2 1939
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

09649

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt Savage
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: main St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: main St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jaco Beanie Neff

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles Neff

6(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Feb 23

8. AGE: Years: 75 Months: 7 Days: 12 If less than one day: hrs. min.

9. Birthplace: Eckhart Alleg. Md.
(Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER
12. Name: Charles Connor
13. Birthplace: Scotland

MOTHER
14. Maiden name: Mary Ann Mathews
15. Birthplace: U.S.A.

16. Informant: Mr Charles Neff

Address: Mt Savage, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-7-39 (month) (day) (year)

Cemetery ~~or crematory~~: Rose Hill

Location: Hagerstown Md

18. Funeral director: J. J. Durst

Address: Frostburg, Md

19. Oct 6 1939 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1939, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1939 to Oct 5 1939 and that I last saw her alive on October 4 1939.

Immediate cause of death: Cardiac Dilatation (acute) — DURATION: 2 hours

Due to —

Due to

Other conditions: Lobar pneumonia — 4 days
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. C. Cohen M. D. or other

Address: Frostburg, Md. Date signed: Oct. 5 1939

RECEIVED
NOV 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (154)

CERTIFICATE OF DEATH

CB 09650

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or Inst. (yrs., or mos., or days): 5 days
Stay in this community (yrs., or mos., or days): 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Mineral ✓
City or town: Ridgely Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Corner, Main & Silver Streets
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Woodrow Wilson Null

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mabel Miller
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 2, 1913

8. AGE: Years	Months	Days	If less than one day
26	2	23	hrs. min.

9. Birthplace: Ridgely, West Virginia
(Town, county, and state)

10. Usual occupation:
11. Industry or business: Celanese

FATHER
12. Name: John Null
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma Burkett
15. Birthplace: Maryland

16. Informant: John Null
Address: Ridgely, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1939 (month) (day) (year)
Cemetery or crematory: Greenmont Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Oct. 28, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-25-39 - 19__, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19__ to 10-25-1939, and that I last saw him alive on 10-25-1939

Immediate cause of death: Septicaemia — DURATION: 5 days

Due to: Ch. Maxillary sinusitis & Ethmoiditis — DURATION: 4 yrs. mo.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Osteomyelitis of Rt upper maxilla & Ethmoid Capsule.
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Leslie E. Daugherty M. D. or other
Address: Cumberland Md Date signed 10-26-39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

CERTIFICATE OF DEATH

09651

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 58 days
Stay in this community (yrs., or mos., or days) 76 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 205 Greene Street (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME PAISLEY, WILLIAM D.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife DECEASED
WAYS, AGNES 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1863

8. AGE: Years	Months	Days	If less than one day
76	3	3	hrs. min.

9. Birthplace MD. (Town, county, and state)
10. Usual occupation AUDITOR
11. Industry or business Public

FATHER
12. Name PAISLEY, DONALD - DECEASED
13. Birthplace SCOTLAND

MOTHER
14. Maiden name COLLINS, ELIZA JANE - DECEASED
15. Birthplace VERMONT

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 11, 1939 (month) (day) (year)
Cemetery or crematory St. Patrick Cemetery
Location Cumberland, Maryland
18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. Oct. 10 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. W.F. WMS.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1939, at 9:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-11- 1939, to 10-8- 1939, and that I last saw h alive on 10-8- 1939.

Immediate cause of death Chronic Myocarditis Coronary Sclerosis Cirrhosis of Liver — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed Oct 11

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(48) CB

09652

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 mo. 11 days.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Morgan

City or town Paw Paw Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Quilia Mae Parks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband or wife Wm Parks

6(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1890

8. AGE: Years	Months	Days	If less than one day
49	0	0	hrs. min.

9. Birthplace Grafton, Taylor Co. W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name Adolphus De Moss

13. Birthplace Taylor County. W. Va.

MOTHER 14. Maiden name Missouri Satterfield

15. Birthplace Taylor County W. Va.

16. Informant William A. Parks

Address Paw Paw, W Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14, 1939. (month) (day) (year)

Cemetery or crematory Camps Hill Cemetery

Location Paw Paw

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19. Oct 17 1939 (Date rec'd by registrar) Joseph L. Faulconer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1939, at 3050 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2, 1937 to Oct 11 1939 and that I last saw h- alive on Oct 10 1939.

	DURATION
Immediate cause of death Carcinomatosis	3yrs?
Due to Carcinoma cervix	
Due to Adeno	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M. D. or other

Address Cumberland Md. Date signed 10-11-39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120)

CERTIFICATE OF DEATH

09653

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 hour

Stay in this community (yrs., or mos., or days) 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Md Savage Road R.D.#1

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Shannon W Porter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1937

8. AGE: Years 2 | Months 4 | Days 10 | If less than one day ____hrs. ____min.

9. Birthplace Barrelville, Maryland, Alle. Co.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John E. Porter

FATHER 13. Birthplace Mt. Savage, Maryland

MOTHER 14. Maiden name Bessie M. Wright

MOTHER 15. Birthplace Chaneyville, Penna.

16. Informant John E. Porter

Address Corrigansville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25, 1939 (month) (day) (year)

Cemetery or crematory Chaneyville Cemetery

Location Chaneyville, Penna.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Oct 23 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1939, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1939, to Oct 22 1939, and that I last saw him alive on Oct 22 1939.

Immediate cause of death	DURATION
acute Enteritis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Allan S. Mann M. D. or other

Address 41 Emmert Cr Cumberland Md Date signed Oct 23 39

RECEIVED
NOV 7 1939
BUREAU Y. S.

WITHIN CORPORATE LIMITS.

09654

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (210-m)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Hampshire

City or town: Romney Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Newton B. Rannells

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Wnite	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. , 1902

8. AGE: Years	Months	Days	If less than one day
37	2		____ hrs. ____ min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER
12. Name: Edward Rannells
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Addie Elizabeth Taylor
15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial and Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 18-1939 (month) (day) (year)

Cemetery or crematory: Three Churches Cemetery

Location: Three Churches. W.Va.

18. Funeral director: Thrush's

Address: Romney. W. Va.

19. 10/17/ 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1939, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct-15- 1939, to Oct-16 1939 and that I last saw him alive on Oct-16 1939.

Immediate cause of death: Fractured Skull crushed Chest.

Due to: Automobile accident

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Oct-15-39

Where did injury occur? Near Romney (City or town) (County) W Va (State)

Injured at home, farm, industry, public place (where?) W Va Highway

Means of injury: Injured at work?

23. SIGNATURE: A C Enfield M. D. or other

Address: Cumberland Date signed: Oct 16-39

DR. ENFIELD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09655

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: R.D. #1 Artemus Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Boy Robinson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1939.

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hrs. 0 min.

9. Birthplace: Cumberland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Chester Robinson

FATHER — 13. Birthplace: Penna.

MOTHER — 14. Maiden name: Genieve Mallott.

MOTHER — 15. Birthplace: Penna.

16. Informant: Chester Robinson

Address: R.D. #1. Artemus, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22, 1939 (month) (day) (year)

Cemetery or crematory: Fairview Ce m.

Location: Near Artemus, Penna.

18. Funeral director: J. C. Wolford

Address: Cumberland

19. Oct. 21, 1939 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at birth, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Still Born	
Due to Toxemia of Pregnancy	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R.C. Barnes M.D.
M. D. or other

Address: Cumberland Md Date signed 10-22-39

RECEIVED
NOV 7 1931
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93c)

Reg. Dist. No. 4

09656

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County: Allegany

(b) City or town: Cumberland
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 810 Columbia Ave.

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in this community (yrs., mos., or days):

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State: Md. (b) County: Allegany

(c) City or town: Cumberland
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 810 Columbia Ave.
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME**: Mrs. Rose Nell Rompf

3 (b) If veteran, name war:

3 (c) Social Security No.: None

4. Sex: Fem.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Rompf

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1872.

8. **AGE:** Years: 67 Months: 1 Days: 0 If less than one day: ____ hr. ____ min.

9. Birthplace: Mt. Savage Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER
12. Name: Joshua Leasure
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Rowe
15. Birthplace: Maryland

16 (a) Informant: Mrs. S. A. McCullough
(b) Address: 810 Columbia Ave. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 13, 1939 (month) (day) (year)
(c) Cemetery or crematory: Rose Hill Cem.
Location: Cumberland

18 (a) Funeral director: J. C. Wolford
(b) Address: Cumberland, Md.

19 (a) Oct. 12, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death: Oct. 11, 1939, at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 39 to Oct 11 1939, and that I last saw him alive on Oct 10 1939.

Immediate cause of death	Duration
Acute Dilatation	
Due to Chronic Myocarditis,	
Due to	
Other conditions Pulmonary Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. **Signature**: A C Enfield (M. D. or other)

Address: Cumberland Date signed: Oct 11-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

OCT 24
BUREA

WITHIN CORPORATE LIMITS.

09657

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 14 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 539 Green Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Adah Rosenmerkel

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Ellsworth Rosenmerkel

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): November 6, 1884

8. AGE: Years	Months	Days	If less than one day
54	11	12	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER
12. Name: John Peebles
13. Birthplace: Scotland

MOTHER
14. Maiden name: Rachael Morgan
15. Birthplace: Wales

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21, 1939 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: M. Eichhorn

Address: Lonacoming, Md.

19. Oct. 20, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. HAWKINS

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18, 1939, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1939, to October 18, 1939, and that I last saw her alive on October 18, 1939.

Immediate cause of death: Myocardial Failure (Dr Williams)

Due to: Pulmonary Embolism

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings: 10-7-39

Of operation: Hysterectomy for fibroids & prolapse of ulcers

Of autopsy: No. Gall bladder filled with stones - not removed

DURATION: 6 or 8 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. H. Hawkins M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

09658

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany.

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 944 Gay St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany.

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 132 Utica St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Rebecca Jane Ross.

3. (b) Social Security Number: None

4. Sex: Fem.

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Edward H. Ross.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 17, 1886

8. AGE: Years 52 Months 11 Days 29 If less than one day ____ hrs. ____ min.

9. Birthplace: Uniontown Penna. (Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business

FATHER

12. Name: Wm C. Thompson.

13. Birthplace: Penna.

MOTHER

14. Maiden name: Mary Poston

15. Birthplace: Penna.

16. Informant: Mrs. Mary M. Porter

Address: 107 Humbird St.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 10/18/39 (month) (day) (year)

Cemetery or crematory: Eckhart.

Location: Eckhart Md.

18. Funeral director: J. C. Walford

Address: Cumberland Md.

19. Oct. 17, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16th., 1939 Probably about at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Chronic Myocarditis

Due to

Due to

Other conditions: Chronic Alcoholism

(Include pregnancy within 8 months of death)

Major findings:

Of operations: ----

Of autopsy: none

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Bruce H. Boxon, M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 10/16/39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (958)

09659

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 27 years
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND, MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 443 CENTRAL AVE.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ~~MR. CHESTER SCARLETT~~ Chester Benjamen Scarlett

3. (b) Social Security Number 217-10-1986

4. Sex MALE
5. Color or race WHITE
6. (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife VIRGINIA JONES
6 (c) If alive, give age 22 years
7. Birth date of deceased (mo., day, yr.) MARCH 5, 1912
8. AGE: Years 27 Months 7 Days 11 If less than one day ___ hrs. ___ min.
9. Birthplace MARYLAND, Cumberland
(Town, county, and state)
10. Usual occupation W. P. A.
11. Industry or business
FATHER
12. Name RICHARD SCARLETT
13. Birthplace WEST VIRGINIA
MOTHER
14. Maiden name CLARA SHEWBRIDGE
15. Birthplace WEST VIRGINIA
16. Informant CHESTER SCARLETT
Address 443 CENTRAL AVE., CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 18, 1939 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Maryland
18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland
19. Oct. 17, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. R. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 16, 1939 19 12:45 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/7/39 19 to 10/16/39 19 and that I last saw him alive on 10/15/39 19

Immediate cause of death Myocardial Failure
Due to Rheumatic Cardio Vascular Disease
Due to Rheumatic fever.
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard J. Williams, MD M. D. or other
Address 34 Va. Ave., Cumberland, Md Date signed 10/16/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 30 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09660

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 4 m 15 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Grantsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs. Fannie Schaeffer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Henry A. Schaeffer

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1889

8. AGE: Years: 50 Months: 5 Days: 13 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Eli Lohr
13. Birthplace: Maryland

MOTHER
14. Maiden name: Barbara Bender
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-9-39 (month) (day) (year)
Cemetery or crematory: Grantsville Cemetary
Location: Grantsville Md
18. Funeral director: Wm Winterberg
Address: Grantsville Md

19. Oct 6 1939 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1939, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1939 to Oct 6 1939, and that I last saw h alive on Oct 6 1939.

Immediate cause of death	DURATION
Carcinomatosis	
Due to Carcinoma of Rectum	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Carcinoma of Rectum
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. G. Bacie M. D. or other
Address: Cumberland Date signed Oct 6-39

RECEIVED
NOV 7 1930
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-d)

CERTIFICATE OF DEATH

09661

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D.#2, Baltimore Pike
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

~~Baby Girl~~ See, Hazel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 17, 1939

8. AGE:

Years	Months	Days	If less than one day
			hrs. 20 min.

9. Birthplace Memorial Hospital, Cumberland Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Hayes See
13. Birthplace West Virginia

MOTHER
14. Maiden name Clarice Reed
15. Birthplace West Virginia

16. Informant Hayes See
Address Baltimore Pike, Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 18, 1939 (month) (day) (year)

Cemetery or crematory Jurgensruck Cem

Location Williams Rd Cumberland

18. Funeral director Mr. Arlie Reed - Grandfather

Address Williams Rd, Cumberland Md

19. Oct. 18, 1939 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1939, at 10:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1939 to Oct 17 1939 and that I last saw h~~e~~r alive on Oct 17 1939.

Immediate cause of death Developmental deformity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? no
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. Owen
M. D. or other

Address 133 Va Ave Date signed 10/18/39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09662

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 420 Oldtown Road, East
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 420 Oldtown Road, East
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elizabeth Jane Shaw

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Amos Eugene Shaw
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1885

8. AGE: Years: 54 | Months: 0 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Scotdale, Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: William A. Morris
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Jane Hriks
15. Birthplace: Wales, England

16. Informant: Amos Eugene Shaw
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1939 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md;
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Oct. 13, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Interments

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9, 1939 to Oct 12 1939
and that I last saw her alive on Oct 11 1939

Immediate cause of death: Chronic Myocarditis — DURATION: 1 year

Due to:

Due to:

Other conditions: Angina Pectoris attacks for last month
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. W. Trevaskis, M. D.
M. D. or other
Address: Cumberland, Md. Date signed: Oct 12-39

RECEIVED
NOV 7 1939
BUREAU OF S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F) 13

09663

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNA. County SOMERSET
City or town MEYERSDALE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
MRS. MISSOURI SHOEMAKER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife SYLVESTER SHOEMAKER
6(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) MAY 12 1873

8. AGE: Years	Months	Days	If less than one day
66	4	25	hrs. min.

9. Birthplace PENNA.
(Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business
FATHER 12. Name JESSE GOMER
13. Birthplace ?
MOTHER 14. Maiden name MELINDA ?
15. Birthplace ?
16. Informant J. M. SHOEMAKER
Address MEYERSDALE, PENNA.
17. Burial Date thereof Oct. 10 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Temple Church
Location Larimer Township, Penna
18. Funeral director A Rech & Son
Address Meyersdale Pa.
19. Oct. 7 1939 J. B. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 7, 1939 at 4;25 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 1939, to October 7, 1939, and that I last saw her alive on October 6, 1939

Immediate cause of death	DURATION
Carcinoma Head Pancreas,	
Due to Metastasis to liver	
Due to Extension —	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations No operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A H Hawkins
M. D. or other
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. HAWKINS

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

09665

(51-B) (B)

1. PLACE OF DEATH

County Allegany — Registration Dist. No. 4

Village or City Cumberland — No. Memorial Hospital — St. 6-6 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 3 yrs. mos. ds. 1 day — How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME (Dr.) George Julian Sibley — If U. S. Veteran, specify WAR Northern

(a) Residence: No. 1264 West 83rd Street St., Ward. Los Angeles, Cal.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Harwood 48 yrs.

6. DATE OF BIRTH (month, dey, and year) August 14, 1884

7. AGE Years	Months	Days	If LESS then 1 dey, hrs. or min.
55	1	18	

OCCUPATION

8. Trade, profession, or perticuler kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Dentist

9. Industry or business in which work was done, es SILK MILL, SAW MILL, BANK, etc. U. S. Army

10. Deto deceesed last worked et this occupation (month end year)

11. Total time (years) spent in this occupetion

12. BIRTHPLACE (city or town) (Stete or country) Maryland

FATHER

13. NAME Julian Sibley

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Mary Beck

16. BIRTHPLACE (city or town) (Stete or country) Maryland

17. INFORMANT (Address) Mr. Harry Irving, Cumb'd, Md.

18. BURIAL, CREMATION, OR REMOVAL

Piece Arlington Cem. WASHINGTON, D.C. Date October 4, 19 1939

19. UNDERTAKER (Address) Louis Stein, Inc. Cumberland, Maryland

20. FILED Oct. 3, 1939 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct. (Month) 2 (Dey), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1939, to Oct 2, 1939

I lest sew him elive on Oct 1, 1939; deeth is said to have occurred on the date stated ebove, et 2:30 p.m.

The PRINCIPAL CAUSE OF DEATH and releted causes of importence were es follows:

	Date of onset
Uremic Coma	Oct 1-39
Chronic Nephritis	5 yrs

Other Contributory Causes of Importance:

Malignant Growth in Bladder	3 yrs

Neme of operation — Date of

What test confirmed diagnosis? — Was there en autopsy?

23. If deeth was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Wes diseese or injury in any way releted to occupation of deceased?

If so, specify

(Signed) Thos. W. Kane M. D.

(Address) Cumberland Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED OCT 13 1928 PUBLIC H. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09666

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 day 9 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Douglas Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ←

3. (a) FULL NAME ← Baby " Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	←

6 (b) Name of husband or wife ←

B(c) If alive, give age ← years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1939

8. AGE:

Years	Months	Days	If less than one day
←	←	1	9 hrs. ___ min.

9. Birthplace Lonaconing, Md. (Town, county, and state)

10. Usual occupation ←

11. Industry or business ←

FATHER

12. Name William Smith

13. Birthplace Lonaconing, Md

MOTHER

14. Maiden name Mabel Miller

15. Birthplace Klondike, Md.

16. Informant Mr. William Smith

Address Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 17, 39 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. Oct 17 1939 (Date rec'd by registrar) Dr. E. Don Fyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Oct~~ October 16th 1939, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1939, to Oct 16 1939, and that I last saw h~~im~~ alive on Oct 16 1939.

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M. D. or other

Address Lonaconing Md Date signed Oct 17 39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

CERTIFICATE OF DEATH

(B) 09667

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 6 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.VA. County GRANT ✓
City or town PETERSBURG. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
SMITH, ANNA L. MRS.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife SMITH, WILLIAM
6(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) APRIL 7 1870

8. AGE: Years	Months	Days	If less than one day
69	6	1	hrs. min.

9. Birthplace W.VA.
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name BROWN, JOHN
13. Birthplace W.VA.

MOTHER
14. Maiden name JONES, RACHEL
15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10-1939 (month) (day) (year)
Cemetery or crematory Petersburg Cemetery
Location Petersburg, W.Va.
18. Funeral director D. E. Thrush & Son
Address Petersburg W.Va.
19. Oct. 9 1939 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER. 8, 1939, at 1:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5, 1939, to October 8, 1939, and that I last saw her alive on October 8, 1939

Immediate cause of death — DURATION

Due to Enforgled Gallbladder. 3 mos. days

Due to Gall stone of Gallbladder.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other
Address Date signed

DR. W.F. WMS.

RECEIVED
NOV 7 1939
BUREAU M. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (34) CB Reg. Dist. No. 6

CERTIFICATE OF DEATH

09664

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Westernport (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Reeve's Clinic

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State W. Va. (b) County Mineral

(c) City or town New Creek (If outside city or town limits, write RURAL and give town)

(d) Street No. New Creek Drive (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** William Reed Smith

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nellie May Smith

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1876

8. **AGE:** Years 63 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Jonesburg, Tenn. (Town, county, and state)

10. Usual occupation Painter & Paper Hanger

11. Industry or business

FATHER

12. Name Samuel Smith

13. Birthplace Do not know

MOTHER

14. Maiden Name Do not know

15. Birthplace

16 (a) Informant Mrs. Nellie May Smith

(b) Address New Creek, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18, 1939 (month) (day) (year)

(c) Cemetery or crematory Queen's Point

Location Keyser, W. Va.

18 (a) Funeral director J. H. Markwood, Sons

(b) Address Keyser, W. Va.

19 (a) Oct. 17, 39 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death 10-15 1939, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1939 to 10-15 1939, and that I last saw him alive on 10-15 1939

Immediate cause of death Cirrhosis of liver

Due to alcoholic & Lues

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D. or other

Address Westernport Md Date signed 10-15-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09668

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany Hosp.

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital Decatur St

Stay in hospital or inst. (yrs., or mos., or days) 34 hours

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Ridgely, West Virginia Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Blocker & Lime Streets

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sandra Spangler

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1936

8. AGE:

Years	Months	Days	If less than one day
3	2	28	hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Robert Spangler

13. Birthplace West Va

MOTHER

14. Maiden name Anna Lambert

15. Birthplace West Virginia

16. Informant Robt Spangler

Address Ridgely, W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12, 1939 (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland Maryland

18. Funeral director Virgil L. Lemperker

Address 707 Greene Street.

19. Oct. 12 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10, 1939, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-9 1939, to 10-10 1939, and that I last saw h alive on 10-10-39 1939.

Immediate cause of death accidental burns — DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10-9-39

Where did injury occur? Ridgely West Va. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Barn

Means of injury Injured at work?

23. SIGNATURE W. Alfred Va Orns M. D. or other

Address Cumb. Md Date signed 10-12-39

Hon. Van Armen

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(182)

09669

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 103 East 5th Street
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 103 East 5th Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Joseph Michael Stinebaugh
3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife —
6(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept 29-1939
8. AGE: Years | Months | Days 4 | If less than one day hrs. min.
9. Birthplace Maryland - Cumberland (Town, county, and state)
10. Usual occupation —
11. Industry or business —
FATHER 12. Name Robert Stinebaugh
13. Birthplace Maryland
MOTHER 14. Maiden name Fanny Lagratta
15. Birthplace Maryland
16. Informant Robert Stinebaugh
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 3, 1939 (month) (day) (year)
Cemetery or crematory St Patricks Cemetery
Location Cumberland, Md
18. Funeral director V. L. Lemperer
Address Cumberland, Md
19. Oct. 2 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1939, at 10 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1939 to Oct 2 1939, and that I last saw him alive on Sept 1 1939.

Immediate cause of death — DURATION
Due to Accidental Suffocation — Inst
Suffocation by Bedclothes.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10/2/39
Where did injury occur? Cumberland (City or town) Allegany (County) Work (State)
Injured at home, farm, industry, public place (where?) no
Means of injury — Injured at work?

23. SIGNATURE M. B. Owens M. D. or other
Address 133 Va Ave Date signed 10/2/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

69670

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 423 N. Centre St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 423 N. Centre St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Johnson Dorwin Tewell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Eveline Northcraft
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1858

8. AGE: Years	Months	Days	If less than one day
81	1	19	hrs. min.

9. Birthplace Shaneysville Bedford Co, Pa.
(Town, county, and state)
10. Usual occupation Merchant.
11. Industry or business Grocery & General.
FATHER 12. Name George Tewell
13. Birthplace Shaneysville, Pa.
MOTHER 14. Maiden name Martha Bashley
15. Birthplace Shaneysville, Pa.
16. Informant Scott Tewell,
Address 423 N. Center - Cumberland, Md.
17. Burial Date thereof Oct 5, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill
Location Cumberland, Md.
18. Funeral director Jacob Hafer
Address Cumberland, Md.
19. Oct. 3 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1939, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1939 to Oct 2 1939, and that I last saw him alive on Oct 1 1939

Immediate cause of death	DURATION
Uremia in Coma	1 Week
Due to Chronic Nephritis	3 yrs
Due to Arteriosclerosis	3 yrs
Other conditions and age	

(Include pregnancy within 3 months of death)

Major findings:
Dt operations
Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos. N. Kraus M. D. or other
Address Cumberland, Md Date signed Oct. 3-39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09671

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County ALLEGANY COUNTY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 7 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State WEST VIRGINIA County HAMPSHIRE

City or town KIRBY Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ISAAC FRANKLIN TIMBROOK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife SALLIE FREY

DECEASED 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JANUARY 2, 1870

8. AGE:

Years	Months	Days	If less than one day
69	9	27	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation FARMING & LUMBERING

11. Industry or business

FATHER 12. Name WILLIAM TIMBROOK (DECEASED)

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name SUSAN RUCKMAN (DECEASED)

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1939 (month) (day) (year)

Cemetery or crematory Hott's Chapel

Location Kirby, W. Va.

16. Funeral director W. H. McKee

Address Augusta, W. Va.

19 Oct 31, 19 39 J. P. Franklin W. Va

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 29 19 39, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-22- 19 39, to 10-29 19 39, and that I last saw him alive on 10-29- 19 39

Immediate cause of death Coronary Thrombosis

Arteriosclerosis

Due to

Due to

Other conditions Benign hypertrophy Prostate

(Include pregnancy within 3 months of death)

DURATION: about 10 yrs.

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard P. Olson M. D. or other

Address Cumberland, Md. Date signed 10-29-39

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09672

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Jackson St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 Months 15 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Jackson, St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Dorothy V. Tinney

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	child

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 29, 1939

8. AGE: Years — Months 5 — Days 15 — If less than one day ____ hrs. ____ min.

9. Birthplace Lonaconing, Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Alph Tinney

13. Birthplace Moscow, Md

MOTHER 14. Maiden name Dorothy Livingston

15. Birthplace Frostburg, Md

16. Informant Mrs. Clara Tinney

Address Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15, 1939 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. Oct. 14 1939 (Date rec'd by registrar) Dr. E. Boyd Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1939, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13 1939, to Oct 14 1939, and that I last saw h[er] alive on Oct. 13 1939

Immediate cause of death	DURATION
Acute gastro enteritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Henry M. Hodgson M.D. M. D. or other

Address Lonaconing, Md Date signed Oct 14 '39

RECEIVED
NOV 7 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

09673

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town R.F.D.# 1 Cumberland (Locust Grove)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Gilmore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. Frostburg
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joseph Ellsworth Tipton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Emma Dawson Tipton

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) ? Unknown

8. AGE:

Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace Mannschoice, Pa
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business On Farm

FATHER 12. Name Geo. W. Tipton

FATHER 13. Birthplace Mannschoice Pa

MOTHER 14. Maiden name Nettie Leach

MOTHER 15. Birthplace Buffalo Mills, Pa.

16. Informant Lee Thrasher

Address Locust Grove Md

17. Burial Date thereof Oct. 15, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Old Coney Cemetary

Location Lonaconing, Md.

18. Funeral director Jacob Hafer

Address Cumberland, Md

19. Oct. 16 14 39 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1939, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4 1939 to 10-13 1939 and that I last saw h- alive on 10-12-13 39.

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	?
Due to (b) Acute dilatation of Heart	
Due to (c)	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Williams
M. D. or other

Address Cumberland Date signed 10/14/39

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94e)

09674

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insl. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 35 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James Tinly

3. (b) Social Security Number: 219-09-6579

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

B (b) Name of husband or wife: alice Aldridge Tinly

6(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Sept. 9 1890

8. AGE: Years: 49 | Months: 1 | Days: | If less than one day: hrs. min.

9. Birthplace: Lonaconing, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER 12. Name: William Tinly

FATHER 13. Birthplace: Nova Scotia

MOTHER 14. Maiden name: Margaret Graham

MOTHER 15. Birthplace: Scotland

18. Informant: Mrs. Alice Tinly
Address: Lord, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 12, 1939 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md

18. Funeral director: M. E. Dickhaus
Address: Lonaconing, Md

19. Oct 11 1939 (Date rec'd by registrar) Dr. E. Dan Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 9th 1939, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Sudden death ~~to~~ at time of attention, and that I last saw h alive on 19

Immediate cause of death: Probably Coronary Occlusion — DURATION

Due to: Found dead on arrival

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M.D. Authorized by Dr. L. H. Corson
M. D. or other
Address: Midland, Md. Date signed: Oct. 10, 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 7 1939
BUREAU F. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

09675

CB

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) FIVE DAYS
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State FRIEDENS County SOMERSET
City or town PA. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME CATHERINE WALKER, MRS.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife ALLEN WALKER

6(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) APRIL 8, 1895

8. AGE: Years	Months	Days	If less than one day
44	6	7	hrs. min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name J. Z. MILLER
13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name ALICE LAMBERT
15. Birthplace PENNSYLVANIA

16. Informant Memorial Hospital
Address Cumberland, Md

17. Burial & Removal Date thereof Oct. 18, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Walker Cem
Location Shanksville, Penna

16. Funeral director John H. Deaner
Address Shanksville, Penna.

19. Oct. 18, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 3:30 P

20. DATE OF DEATH OCTOBER 15, 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-10-1939, to 10-15-1939, and that I last saw her alive on 10-15-1939

Immediate cause of death	DURATION
Renal Polycystic disease	Congenital
Chr. Nephritis	
Due to Secondary anemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Folson M.D. or other
Address Cumberland, Md Date signed 10-16-39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (151)

CERTIFICATE OF DEATH

09676

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Sybran Retreat

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Lonaconing Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dominick Warnick

3. (b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: J

8 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years: 72 | Months | Days | If less than one day: hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name Brown

15. Birthplace

18. Informant Sybran Retreat

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24 39 (month) (day) (year)

Cemetery or crematory Allegany Co Cem.

Location Cumberland Md.

18. Funeral director Louis Stein, Doc

Address Cumberland.

19 Oct. 24 19 39 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 22 - 1939, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 9 - 1938, to 10 - 22 - 1939, and that I last saw him alive on 10 - 20 - 1939.

Immediate cause of death: Chr. Myocarditis — DURATION 2

Chr. Nephritis

Due to Arteriosclerosis

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 10-23-39

RECEIVED
NOV 7 1939
BUREAU V. S.

Outside of City Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

CERTIFICATE OF DEATH

09677

1. PLACE OF DEATH

(a) County Allegany

(b) City or town Spring Gap (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 40 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Spring Gap (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME CHARLES WALTER WHEELER

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color, or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1876

8. AGE: Years 63 | Months 5 | Days 8 | If less than one day _____ hr. _____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Steam shovel operator

11. Industry or business

FATHER

12. Name Wm. B. Wheeler

13. Birthplace Ohio

MOTHER

14. Maiden Name Delilah Davis

15. Birthplace Maryland

16 (a) Informant John P. Wheeler

(b) Address Spring Gap, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15, 1939 (month) (day) (year)

(c) Cemetery or crematory Wheeler Cemetery

Location Spring Gap, Md.

18 (a) Funeral director Louis Stein, Inc.

(b) Address Cumberland, Maryland

19 (a) Oct. 15, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death Oct 13 1939, at 7:00 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1939, to Oct 13 1939, and that I last saw him alive on Oct 13 1939.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature S. E. Ergood M. D. or other

Address Cumberland Date signed Oct 15

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (153)

CERTIFICATE OF DEATH

09678

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 18 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Slabtown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Mt. Savage
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Melvin Earl Winebrenner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5 1939

8. AGE: Years | Months 2 | Days 24 | If less than one day hrs. min.

9. Birthplace Allegany County, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Winebrenner

13. Birthplace Allegany Co., Md.

MOTHER 14. Maiden name Cathleen O'Brien

15. Birthplace Allegany Co., Md.

16. Informant John Winebrenner

Address Slabtown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1939 (month) (day) (year)

Cemetery or crematory St. Michaels Cem

Location Frostburg, Md

18. Funeral director John Winebrenner - Father

Address Slabtown Md

19. Oct. 30 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1939, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1939 to Oct 29 1939, and that I last saw him alive on Oct 29 1939

Immediate cause of death	DURATION
Marasmus	
Due to Improper feeding	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wade B. Johnson M. D. or other

Address Cumberland, Md Date signed 11-3-39

RECEIVED
NOV 7 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

09679

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R.F.D. #3, Bedford Road

Stay in hospital or inst. (yrs., or mos., or days): --

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #3, Bedford Road (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Alice E. Wolfe

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George A. Wolfe

6(c) If alive, give age: 87 years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1867

8. AGE: Years 71 | Months 10 | Days 0 | If less than one day ___ hrs. ___ min.

9. Birthplace: Adams Co., Pennsylvania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Henry Miltenberger
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Alice E. (?)
15. Birthplace: Pennsylvania

16. Informant: Mrs. J. Henry Wolfe

Address: 306 Beall St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1939 (month) (day) (year)

Cemetery or crematory: St. P. & P. Cemetery

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Oct. 13 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Rozum

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11, 1939, at ___ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19__, to ___ 19__, and that I last saw her alive on 10/7/39 19__.

Immediate cause of death: Carcinoma rectum

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ___ Injured at work?

23. SIGNATURE: John K Rozum M.D. M. D. or other

Address: Cumberland Md. Date signed: 10/13/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-a

CERTIFICATE OF DEATH

69680

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 50 Mill St., (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Wright

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Mary

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8 - 1879.

8. AGE: Years	Months	Days	If less than one day
60	7	14	hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER — 12. Name: John Wright

13. Birthplace: England

MOTHER — 14. Maiden name: Jemima Hendley

15. Birthplace: England

16. Informant: George Wright

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28-1939 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md

18. Funeral director: J. J. Hirst

Address: Frostburg Md

19. (Date rec'd by registrar) 19 10-28-39 Mrs. A. R. Walker Registrar

(Mrs. A. R. Walker)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1939, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1939, to Oct 26 1939, and that I last saw him alive on Oct 25 1939.

Immediate cause of death	DURATION
Cerebral Hemorrhage	6
Due to Arteria Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no

Of autopsy: No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane M.D. M. D. or other

Address: Frostburg Md. Date signed: Oct 27 1939

RECEIVED
NOV 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

09681

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 14 Green St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Catherine Yeagers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife: George Yeager

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec 17 1877

8. AGE:

Years	Months	Days	If less than one day
62	10	3	____ hrs. ____ min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At home

FATHER
12. Name: Andrew Franme
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Gilley
15. Birthplace: Germany

16. Informant: Mrs George Yeager

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24 1939. (month) (day) (year)

Cemetery or crematory: Ste Bernard

Location: Akron, Ohio

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. Oct. 23 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20th 1939, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1939 to Oct 20 1939, and that I last saw h-- alive on Oct 20 1939.

	DURATION
Immediate cause of death: Cardiac Failure	
Post Operative	
Partial Hysterectomy	
Due to Pyloric Obstruction	
Due to Malignancy of Stomach	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings:
Of operations: Pyloric obstruction due to malignancy

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: R. C. Bowers M.D.
M. D. or other

Address: Cumberland Md Date signed: 10-21-39

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09682

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Schades Lane

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Schaidts Lane

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Viola May Zembower

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband ~~or wife~~ Percy Zembower

6(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) May 24, 1900

8. AGE: Years 39 | Months 4 | Days 24 | If less than one day ____ hrs. ____ min.

9. Birthplace West Va (Town, county, and state)

10. Usual occupation Housewife and

11. Industry or business Sales Lady Dept Store

FATHER 12. Name James Segrs

13. Birthplace West Va

MOTHER 14. Maiden name Lillian Summers

15. Birthplace West Va

16. Informant Percy Zembower

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20/39 (month) (day) (year)

Cemetery or crematory St. Peter & Paul Cem.

Location Cumberland, Md.

18. Funeral director V. L. Temperance

Address Cumberland Md

19. Oct. 20 1939 J. P. Franklin M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18th., 1939, at 9.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Hemoptysis-probably due to paroxysm of coughing	
A massive pulmonary hemorrhage.	
Due to Not due to tuberculosis. Due to a rupture of a pulmonary vessel. cuteR.	
Due to	
no autopsy was performed.	
Other conditions LaGrippe	2weeks
no more obtainable.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Percy H. Brown M.D.

M. D. or other

Address Cumberland, Maryland Date signed 10/19/39

Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93C)

09683

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 433 Homer Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 433 Homer Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Florence Cordelia Zollner

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John T. Zollner

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 3o, 1866

8. AGE: Years 72 Months 9 Days 25 If less than one day ____ hrs. ____ min.

9. Birthplace Magnolia, West Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name John Mencer

13. Birthplace West Virginia

MOTHER 14. Maiden name Louise Kerns

15. Birthplace West Virginia

16. Informant Mr. O. G. Zollner

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1939 (month) (day) (year)

Cemetery or crematory Magnolia, W.Va. Cemetery

Location Magnolia, W. Va.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Oct. 28 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1939, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15, 1939, to Oct. 25, 1939, and that I last saw her alive on Oct. 22, 1939.

Immediate cause of death Uraemia — DURATION 10 Days

Due to Generalized Arteriosclerosis Chronic Myocarditis 1936.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Durrett M.D. or other

Address Cumberland Date signed Oct. 26, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1939
BUREAU V. S.